

0540: A DESIGNATED ERAS NURSE CONSISTENTLY ACHIEVES ERAS GOALS WITH SIGNIFICANT COST REDUCTIONS FOR THE NHS

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Aim: Enhanced recovery after surgery (ERAS) optimises patient outcomes after elective surgery. The role of designated ERAS nurse has rarely been assessed with limited information on any potential cost savings.

Methods: 3 separate time periods were compared: n = 36, group 1 (ERAS established, no designated nurse, 3 months duration); n = 64, group 2 (5 month introductory period for ERAS Nurse) and group 3, n = 204 (12 months following introductory period) Total numbers of patients; length of hospital stay (LOS); re-admission rates were calculated with daily patient costs estimated using £541 / surgical ward.

Results: LOS reduced in-group 2 and further reduced in group 3: 9 (3–36) vs 8 (3–15) vs 7 (3–68) [Groups 1, 2 and 3 respectively]. The re-admission rate reduced: 8% vs 4.7% vs 5.4%; length of re-admission stay shorter: 4.5 days vs 1.7 vs 1.7.

The two-day LOS reduction saved 408 bed days: potential cost reduction of £1082/patient/ hospital stay or alternatively, allowed extra 58 patients to have surgery.

Conclusion: A designated ERAS Nurse has substantially increased the number of patients undergoing surgery, with further reductions in hospital stay and re-admission rates; a designated ERAS Nurse has vital and cost-effective role in current surgical practice.

0557: QUALITY IMPROVEMENT AUDIT: GENERAL PRACTICE GENERAL SURGICAL REFERRALS

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Aim: To evaluate the quality of general practice (GP) referral documentation to the general surgical unit at Southport and Ormskirk Hospital NHS Trust.

Methods: Prospective data collection of all GP patients referred to general surgery during a 5week period.

Results: A total of 110 referrals were identified; 42 out of normal working hours. 65.5% female; 34.5% male; age range of 16–95years. Of those identified 61.8% arrived with a covering letter; 45.6% handwritten, 54.4% typed. 3 patients (2.6%) had no accompanying documentation, 2 previous operation notes (1.8%), and 1 last clinic letter (0.9%). 67.3% of patients attended with consultation and medical background printout. 93.3% of referral documentation included date; 46.2% time. 73.1% had a medication background, 29.8% covering social history. 12.5% of patients had a full set of observations recorded; 42.1% included no observations.

Conclusion: Clear referral documentation, including thorough past medical history, medication and social history is essential in the acute surgical setting for patient assessment. Observations recorded in the initial review of a patient are vital for appropriate departmental allocation and clinical prioritisation for the on call team. The development of guidelines for GP referrals regarding documentation is key prior to completion of the audit cycle in 12months time.

0572: AUDIT COMPLETION IN SURGERY

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Aim: A completed audit requires measurement against set standards, reporting of results, implementation of change and re-audit (HQUIP audit definition). Despite being a key requirement of training and revalidation, the overall rate of audit completion is unknown. We sought to examine audit activity and establish completion rates, and reasons underpinning failure to complete.

Methods: A standard audit proforma and methodology was established and the project registered across three hospitals. Records were searched for audits registered between 1/4/2011 and 31/3/2012. Audit department

data was reviewed to establish validity and progress of audit. Audit teams were contacted to establish true progress and reasons for failure of completion.

Results: 39 Audits were registered within the General Surgery Directorates. Only 7 completed the audit with recommendation and re-audit according to HQUIP guidelines (18%). Commonest reasons given for failure to complete audit were gaining a required presentation/publication (no on-going desire) and results felt not to be of value to further investigate.

Conclusion: Audit completion rates are low. Our data suggests that audits are often performed to meet training/career progression needs rather than directly to improve patient care. To maximise the efficacy of clinical audit in surgery structured methods are needed to improve completion rates.

0573: IMPROVING THE DETAIL OF POST-OPERATIVE PLANS IN GENERAL SURGICAL PATIENTS

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Aim: To assess the detail of postoperative plans and compare them to standards outlined by the Royal College of Surgeons.

Methods: Twenty general surgical post-operative notes were randomly chosen over a 3 week period. We analysed each plan looking at whether it was electronic or hand written, and if the following 6 parameters were documented: Analgesia plan, thromboprophylaxis, mobilisation, nutrition/feeding, details of drains, and post-operative antibiotics. Initial data was presented at our departmental meeting, followed by the implementation of a poster in each theatre emphasising the inclusion of the above 6 points. After 2 months 20 operation notes were randomly selected and compared to close the audit loop.

Results: Pre and post intervention, notes were electronic in 80% and 100% respectively. Post intervention the inclusion of the 6 parameters improved as shown in brackets. Analgesia 40% (95%), thromboprophylaxis 50% (100%), mobilisation 30% (80%), nutrition/feeding 95% (100%), details of drains 15% (70%), and post-operative antibiotics 35% (90%).

Conclusion: Post-operative plans are vital in providing clear instructions for the multi-disciplinary team. They remove uncertainty, which may lead to complications. Compliance with recommended guidelines prior to intervention was poor. A simple reminder in theatre significantly improved the detail of post-operative plans.

0580: AUDIT (CLOSED LOOP): DAILY REVIEWS: ARE WE SEEING OUR INPATIENTS ON A DAILY BASIS?

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Aim: Principles of best practice states “an organised and disciplined approach to ward rounds...improves patient safety and care”. With this in mind, and an awareness of changing working patterns for junior doctors; are patients still being seen on the Ward Round (WR) every day? The aim of this audit was to assess whether we are reviewing inpatients on a daily basis and on re-audit; have we improved?

Methods: Prospective audit of notes over one week. Review of patient notes on a daily basis after 1630hrs of all adult inpatients in the orthopaedic department

Exclusion of patients under the care of orthogeriatricians.

Re-audit after a month.

Results: Cycle 1: Average 86% patients seen daily (range 83–92%); 98% seen in 48hours, only 24% patients seen at weekend.

Intervention: Departmental education and audit meeting presentation/discussion. New consensus that all patients should be seen during the weekend. Cycle 2: Average 92% patients seen daily (range 85–97%), 98% within 48hrs. 96% seen at weekend

Conclusion: Due to the constraints of working patterns and multiple handovers there is a risk of patients being missed during the daily WR. Having identified this issue within our department, changes were made to improve performance and hopefully patient care.

0621: IMPROVING STANDARDS IN RADIOLOGY REQUEST FORMS: A SCORING TOOL FOR CLINICAL AUDIT